Office Use: __Demo ___Scan
___Ins ___Phys ___Note

New Patient Intake

DIRECTIONS : *fill out completely; there are multiple pages*

Name: _____ Today's Date: ___ /___ / ___

What brings you into the office today?_____

Date of Birth:___/___/_____ Social Security Number: _____-_____-_____

Address:_____

City:_____ State:_____ Zip Code:_____

Cell #:_____ Email _____

Occupation _____ Employer _____

Single/ Married / Divorced / Widowed: Spouse's Name: _____ # of Children: _____

How did you hear about us? _____

Complaint #1: _____When did it start? _____;
The pain is described as (Circle all that apply):
Dull Achy Stiff Sharp Shooting Stabbing Throbbing Burning Other
It's better with: sitting standing stretching walking lying down
It's worse with: sitting standing stretching walking lying down
I feel it: 0-25% 25-50% 50-75% 75-100% of the time
How much pain? (On a scale of 1-10 with 10 being the worst pain imaginable):
1 2 3 4 5 6 7 8 9 10

Anything else to add? _____

Complaint #2: _____ When did it start? _____;
The pain is described as (Circle all that apply):
Dull Achy Stiff Sharp Shooting Stabbing Throbbing Burning Other
It's better with: sitting standing stretching walking lying down
It's worse with: sitting standing stretching walking lying down
I feel it: 0-25% 25-50% 50-75% 75-100% of the time
How much pain? (On a scale of 1-10 with 10 being the worst pain imaginable):
1 2 3 4 5 6 7 8 9 10

Anything else to add? _____

Quality of Life Survey

List any treatments you have tried in the past for your complaints (medication, surgery, chiropractic, etc.):

_____

How did previous treatment methods work for you? (Circle all that apply):
Great Results Some Results Bad Results Nothing Changed Still Trying

My complaints interferes with my (Circle all that apply):
Sleep Job Marriage Kids Finances Moods Focus Freedom Workouts Ability to lift
Other: _____

How has your complaints/pain interfered with those selected above. Give examples:

_____
_____
_____

Where do you picture yourself in the next 3-4 years if this problem is not taken care of?

_____
_____
_____

What do you hope to obtain through working with us?

_____
_____
_____

How would this improve/better your life?

_____
_____
_____

2024 Health Goals: _____

Rate your Commitment to Feeling Better (scale of 1-10; 10 is most committed):

1 2 3 4 5 6 7 8 9 10

Name of your primary care doctor _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Dental Exam_____ MRI/CT-Scan/Bone Scan_____

Are you Pregnant? (Circle Yes or No): YES NO If YES, Due Date: _____

Falls/Head Injuries: _____

Broken Bones/Dislocations: _____

Surgeries: _____

CIRCLE any symptom(s) you have even if on/off (have had within 1 year) or Diagnosis by a Doctor

Migraine	Hip Pain	Neuropathy	Pinched Nerve	Hepatitis
Tension Headache	Dizziness	Fainting	Kidney Problems	GERD
TMJ	Nausea	Bladder Problems	Appendicitis	Gout
Sciatica	Vertigo	Chest Pains	Thyroid Issues	HIV/AIDS
Low Back Pain	Poor Mobility	Arm Pain/Numbness	ADD/ADHD	Addiction
Leg/Feet Numbness	Hand Numbness	Depression	Tuberculosis	Infertility
Shoulder Pain	Arm/Hand Weakness	Anxiety	Heart Disorders	Lupus
Neck Pain	Anorexia	Stomach Issues	Blood Disorder	Fibromyalgia
Upper Back pain	Whiplash	Constipation	Throat Issues	Hernia
Mid Back Pain	Gout	Cancer	Anemia	
Appendicitis	Ear Infections	Heart Disease	Bronchitis	
Cancer	Diabetes	Glaucoma	Mumps	
Herniated Disc	Bulimia	Mononucleosis	High Cholesterol	
Multiple Sclerosis	Pneumonia	Tonsillitis	Chronic Fatigue	
Diagnosed Arthritis	Pacemaker	Prostate Problems	Stroke	

Social History

Exercise: Days per Week _____; Type of Workouts: HIIT Weights Yoga Bike Run

Work: Average # of hours you sit at work ____; Average hours you stand at work ____.

Habits: Do you smoke? YES NO How many packs/day? ___

Do you drink alcohol? YES NO How many drinks/week? ___

What's your Diet Like? _____

Medications/Allergies/Supplements

Medications	Allergies	Vitamins/Herbs/Minerals

WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However, that does not mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctor determine how we can help your condition.

Please check any and all that apply to you:

Sub-Clinical Symptoms Including:
- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:
- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:
- ☐ Abdominal bloating, cramps, or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:
- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:
- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:
- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:
- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:
- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:
- ☐ Eczema
- ☐ Skin Rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results (0 is none, 3 is severe).

Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (uticaria)	0	1	2	3

Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____

Informed Consent

When a patient seeks chiropractic health care with our facility and we accept a patient for such care, it is essential for both to be working for the same objective as a team to help you in attempting to reach your health goals. This will prevent any confusion or disappointment on either end. We are **very successful** in helping a variety of conditions because our patients are held to a certain standard. If you are not compliant with doctor recommended care we reserve the right to dismiss your case and refer you elsewhere immediately. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo our unique chiropractic/rehab/medical protocols after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.** An adjustment is the specific application of force to correct and/or reduce vertebral subluxation (misalignment that alters physiology). Our chiropractic method of correction is by specific adjustments of the spine and physical rehab. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____

Patient Signature **Date**

Media Release

I consent and authorize JP Chiropractic, located at 1012 Physicians Drive Suite 102, Charleston, SC 29414 to use my likeness in any photograph, video or other digital media ("Photos") in any and all of its publications, including print or web-based publications. I authorize JP Chiropractic to copy, edit, enhance, crop or otherwise alter any photo for use in their publications. I also waive any rights for approval or inspections of any photos or videos. I understand and agree that all photos and videos are the property of JP Chiropractic, and will not be returned to me. I acknowledge that I am not entitled to any compensation or royalties with respect to the use of the photos/videos. I agree to release and forever discharge JP Chiropractic and its affiliates and assigns, offices, employees, representatives, partners, agents and anyone claiming through them, in their individual and/or corporate capacities from any and all claims, liabilities, obligations, promises, agreements, disputes, demands, damages, causes of action of any nature or kind, known or unknown, which I, and anyone claiming on behalf of me, may have or claim to have against release in connection with this release. I understand that I have the right to revoke this consent, in writing, at any time. I have carefully read and fully understand all provisions of this Media Release and am freely, knowingly and voluntarily signing.

_____ _____

Patient Signature **Date**

Insurance and Appointment Policy

No-shows, Cancellations, and Rescheduling Appointment Policy

We reserve the right to charge a $20 missed appointment fee for **no-shows or cancellations** with less than **8-hours** notice.

Assignment of Benefits

I hereby assign all medical/chiropractic benefits, to include major medical benefits, personal injury payments, Medpay payments, to which I am entitled to JP Chiropractic. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan, to issue payment check(s) **directly to JP Chiropractic** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information/Records

I hereby authorize JP Chiropractic to:

(1) release any information necessary to insurance carriers, lawyers and other health care providers regarding my medical history, bills and treatments (past or present)

(2) process insurance claims generated in the course of examination or treatment; and

(3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Our office policy states that payment is due when services are rendered. We attempt to collect all copays and allowables up front to prevent billing confusion post treatment, but we can't always predict exact amounts.

- Cash/Check/Credit Card: Payment is due in full when services are rendered with the exception of care packages purchased- pursuant to that agreement.
- Insurance: We will file your medical insurance for you. We must have a copy of your health insurance card as well as your driver's license for your file. Deductible amounts and co-payment amounts are due in full as services are rendered. We will debit or credit you the difference if we under or overcharge based on your agreement with your insurance company. Any charges not covered by the insurance company will be billed directly to you for payment.
- Personal Injury- Medpay or a letter of protections and/or lien is necessary for auto claims.
- Medicare: We must have a copy of your Medicare card for verification of coverage and any secondary health insurance you may have.

I have requested medical services from JP Chiropractic on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient Signature **Date**

Privacy Practices

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to JP Chiropractic.

I consent to the use or disclosure of my protected health information to the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below. I also consent to receiving correspondence from JPC in the form of text, social or otherwise.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. If Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I reserve the right to request a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices before signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 1012 Physicians Drive Suite 102, Charleston, SC 29414. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

The Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy to be sent by mail or asking for one at the time of my next appointment.

_____ _____

Patient Signature **Date**

Pregnancy Release (Women)

If recommended for further x-ray testing this is to certify that to the best of my knowledge I am ***not*** pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____

Patient Signature **Date**

Minor Consent for Evaluation and Treatment (under 18)

I, _____, the parent or legal guardian of _____, have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care. I also consent to Dr. Pero treating my child if a legal guardian is not present.

_____ _____

Signature **Date**